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ABSTRACT

As family therapy becomes a serious intellectual disipline, the relationships among its leading variations require closer examination. To examine similarities and differences among four closely related approaches (brief, problem-focused therapy; structural family therapy; strategic family therapy; and systemic family therapy) and to determine if the therapy models are most closely related in theory, in practice, or considered variations on a common theme, representatives of four institutes where the models were developed completed a 60-item Family Therapy Questionnaire. Results indicated that despite common roots in cybernetics and systems theory, the four strategic systems therapies appeared to share less in concept than technique. The models shared a practical, strategic orientation to change, but differed in their conceptions of how problems were maintained systemically. In addition, the four approaches were closely enough related to the considered variations of a common clinical, if not theoretical, paradigm. The findings suggest that the systems therapies are growing rapidly, with developments in technique outstripping those in theory and research. (PAS)

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THE STRATEGIC SYSTEMS THERAPIES: MEASURING THE MODELS*

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I would like to thank Joseph B. Eron, an important collaborator in much of this work; Steven R. Brown, who introduced me to Q-sorting; Mark Gelber, who made possible the Skidmore conferences on which the research was based; and the 13 strategic systems therapists who provided the data.

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THE STRATEGIC SYSTEMS THERAPIES: MEASURING THE MODELS

As family therapy becomes a serious intellectual discipline (8), the relationships among its leading variations deserve closer examination. While most comparative studies contrast broad orientations -- psychodynamic, behavioral, experiential, etc. -- this paper examines similarities and differences among four approaches which are closely related: (1) brief, problem-focused therapy, developed by Fisch, Weakland, Watzlawick and others at Palo Alto's Mental Research Institute (2,24); (2) structural family therapy, developed by Minuchin and colleagues (13,14) at the Philadelphia Child Guidance Clinic; (3) strategic family therapy, associated with Haley (6,7), Madanes (10) and the Family Therapy Institute of Washington, D.C.; and (4) systemic family therapy, as formulated by Selvini-Palazzoli and associates (19,20) in Milan, Italy, and applied in this country by Hoffman (8) and others at New York's Ackerman Institute.

That the four models are interrelated should not be surprising given the interwoven careers of their authors: Haley and Weakland were colleagues in Bateson's 1952-62 research project on communication (22), Haley later worked with Minuchin in Philadelphia, Watzlawick was an important consultant to the Milan group, and so on. In practice, each approach assumes that problems are maintained cybernetically in ongoing patterns of family interaction. And in each, the therapist (or team) intervenes deliberately, on the basis of a specific plan, to resolve the presenting problem as efficiently as possible (18).

Madanes and Haley (12) have identified these approaches with a "communication school" of family therapy because they are based on ideas from cybernetics and communication theory, and unlike other schools of family therapy, did not evolve from theories of individual psychotherapy. The term "communication therapy" may be misleading, however, since helping people communicate better is not emphasized in this orientation. A better name might be "strategic

systems therapy", which highlights both a systemic theory of problem maintenance and a strategic orientation to change (18). Finding the right brand names for particular models is also difficult because the common identifiers -- structural, strategic, systemic, etc. -- do not apply uniquely to any one school. Actually, any of the four models could be called "strategic" or "systemic", and at least two (probably three) could be called "structural". Ironically, one of the least applicable labels may be "family therapy", as data below will illustrate.

Most comparative studies of family therapy models attempt to discern similarities and differences from published accounts or direct observations of clinical practices (e.g., 3,5,12,18). The validity of comparison depends on the commentator's perception and analytical skills, and also on his or her neutrality -- which is easily compromised by greater familarity (or affiliation) with one approach than another (17). An alternative method would have proponents of various approaches demonstrate or describe their work themselves, in some common format, and allow the data to speak for themselves.

In the present study, representatives of four institutes where the respective models were developed, or are now actively taught, described their work using a standard Q-sort instrument designed for that purpose. The data address the following questions: (1) What are the main similarities and differences among the four approaches? (2) Are the models more closely related in theory or in practice? and (3) Are they sufficiently interrelated to be considered variations on a common theme, or paradigm?

Raters, Institutes and Models

Prior to a 1981 conference[1], representatives of the Mental Research Institute (MRI), Philadelphia Child Guidance Clinic (PCGC), Family Therapy Institute of Washington, D.C. (FTIW), and the Ackerman Institute for Family Therapy (AIFT)

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[1] "The Structural, Strategic and Systemic Family Therapies: Demonstrations and

Dialogue", Skidmore College, Saratoga Springs, NY, July 23-24, 1981.

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agreed to describe their work using instruments prepared by the author. Data from eight raters — two from each institute (and model) — were included in the main analyses. The respondents were: James Coyne and Lynn Segal (MRI), H. Charles Fishman and Jorge Colapinto (PCGC), Judith Mazza and Richard Belson (FTIW), and Gillian Walker and Peggy Penn (AIFT).[2] All are "second-generation"

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[2] Q-sorts were also provided by Lynn Hoffman, M. Duncan Stanton, Thomas Todd, Monica McGoldrick, and Harold Goolishian. Data from these five respondents are not included in the main analyses, but their relationships to the eight primary Q-sorts are summarized in a later footnote.

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authorities on their respective approaches, and at the time of the study, all but the AIFT participants were working closely with the principal architects of the models they represented. (The Ackerman Institute representatives, while strongly influenced by the Milan associates, were not formally trained by them, nor have they been affiliated directly with the Milan Center for Family Studies. When surveyed, the AIFT respondents indicated their approach was primarily systemic (Milanese), but reflected other influences as well. Hence, the Milan model is not represented as purely in the sample as the other three.)

For ease of presentation, we will identify the four models by referring to their representatives' institutions (MRI,PCGC,etc.), recognizing that doing so risks some degree of misrepresentation. In particular, strategic/systemic therapy is not the only approach taught at the Ackerman Institute, nor is brief problem-focused therapy the only activity at MRI. Still, these clearly have been influential (if not dominant) points of view at the two centers.

Q-Sorts and Questionnaires

Respondents first completed a 60-item Family Therapy Questionnaire (Appendix)

by expressing agreement or disagreement with each item on a 9-point scale. The main task — the Q-sort (23) — consisted of ranking the same 60 statements (each typed on a seperate slip of paper) by sorting them into nine piles, or categories. The categories ranged along a continuum from "least agree" (category 1) to "most agree" (category 9), with a requirement that 3,5,7,10,10,10,7,5, and 3 items be placed in categ ries 1 through 9, respectively. Unlike the Questionnaire, where agree-disagree about each item were absolute, the Q-sort judgements were relative: Even if raters agreed or disagreed with all the statements, they were to indicate which most and least represented their point of view.

The 60 items shown in Appendix 1 were selected to sample the general domain of structural/strategic/systemic therapy: Some mark particular models, others relate to hypothesized similarities and differences outlined elsewhere (18). The statements were classified, after the fact, as pertaining primarily to problem maintenance (theory) or problem resolution (practice). There were 18 problem maintenance and 39 intervention items. Three statements (items 13,28 and 54) were not classified.

Q-sort category scores ranging from 1 to 9 were analyzed in two ways: Item analyses identify statements which define and differentiate the models, whereas correlational analyses (including Q-factor analysis) define relationships among individual Q-sorts and among four averaged Q-sorts representing the models. Because distributions of category scores in the forced-choice format are approximately normal, the overall similarity or agreement between any two Q-sorts can be expressed conveniently as a correlation coefficient. The matrix of correlations between Q-sorts (and therapy models) can also be factor anlyzed to show how the models cluster, and to identify fundamental themes, or factors, around which the Q-sort rankings are organized (16). Used in this way, Q-methodology is a powerful tool for small-sample studies of relationships among points of view.[3]

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[3] Note that correlating people (or Q-sorts) over items inverts the more familiar

procedure of correlating items (or tests) over people. For a discussion of the strengths and limitations of this approach, see Nunnally (16) or Kerlinger (9).

Rater reliability was estimated by correlating Q-sort and Questionnaire responses for each subject over the 60 items. Although several subjects reported difficulty choosing between items they mostly agreed with, the Q-sort ranks closely parallel responses to the Questionnaire, with coefficients ranging from .69 to .88. Correlations between Q-sorts representing the same model ranged from .42 (AIFT) to .74 (FTIW) and exceeded all correlations among Q-sorts for different models.

The Models in Profile

Table 1 lists the items ranked highest and lowest by the two representatives of each model. Included are statements which received average category scores above 7.5 or below 2.5. For economy of presentation, Table 1 shows only item numbers: The corresponding statements may be found in Appendix 1.

Table 1 near here

These items seem to reflect the models fairly well: Thus, MRI raters rank highest the idea that problems are maintained by attempts to solve them (item 27). Most relevant in this approach are the specific interactions which immediately surround the problem (item 39). Little importance is attached to family structure (items 19,39), history (items 20,2), family homeostasis (item 40), or the function a symptom may serve for the family or its members (item 37). Intervention is brief (item 23), goal-directed (items 6,17) and focused on resolving the presenting problem (items 6,1). The therapist's strategy is not shared openly (item 44), and to enhance compliance, suggestions are framed in terms of the clients' own language (item 55). Aesthetics of therapy are not emphasized (item 28).

In the PCGC structural model, symptoms serve a homeostatic function (item 40) for social units of at least three people (item 45) who are either too involved with each other or not involved enough (item 5). The therapist grapples actively with the system as a member (items 35,47), challenging dysfunctional patterns directly, as they occur in the therapy room (item 9), from a stance that is neither neutral (item 53) or detached (items 45,59). Since the meaning of events and behavior is relative (item 32), therapy attempts to redefine reality in more workable ways (item 9). Historical data (items 2,20), goal setting (item 17), and co-therapy (item 12) are of low priority.

The Haley/Madanes FTIW model assumes that symptomatic behavior reflects a confused or incongruous organizational hierarchy (item 7) and may be metaphoric of other problems in the family (item 14). The therapist's objective is to correst the hierarchy (item 26) and resolve the presenting problem (items 1,6). To do so, it is important that he or she be actively in charge of the case (items 18,8), including decisions to medicate, hospitalize and discharge (item 3). Intervention is strategic (items 44,41), often paradoxical (item 56), and based on forming coalitions rather than preserving neutrality (items 59,53). Historical data (items 2,20), co-therapy (item 12), and the consultation-team/one-way-mirror format (item 42) are not emphasized.

AIFT's systemic therapists understand clinical problems in a broad historical context (item 2), valuing genograms and family event charts as assessment tools (item 20). Based on a conceptual problem unit of at least three people (item 45), this approach recognizes that therapy itself can easily become part of the problem (item 46). In the Milan tradition, successful therapy is a process of sequential hypothesis testing (item 51) which relies heavily on reframing (item 41) and positively connoting dysfunctional interaction patterns (item 43). Surprisingly, the AIFT respondents react strongly against identifying their work as family therapy (item 54). Nor do they endorse written interventions (item 45) or co-therapy (item 12), both aspects of the Milan consultation-team format

Consensus Items

If the four models do represent a common paradigm, the Q-sort items most and least endorsed by the eight raters as a group should tell us something about it. Table 2 shows the 10 highest-ranked statements for the institutes combined. (Item numbers for these and the 10 lowest-ranked items also appear in Table 1.)

Table 2 near here

Three of the top four statements (items 41,55,32) concern the meaning people attribute to event and behavior. Since "reality" in this orientation is more "constructed" than "discovered", reframing and using clients' language are important modes of intervention.

Consensus items 6, 15 and 1 highlight pragmatic aspects of therapy — having goals, solving problems, getting results. The strategic theme is clearest in items 44 and 15, which emphasize that the therapist need not (and perhaps should not) share his plan openly with clients. In this view, change follows from deliberate influence rather than education, insight or emotional release. Since influence is inevitable, the question is not whether to influence, but how to do it most effectively. The respondents agree that being in control of treatment (item 3) is an important prerequisite. They are also concerned that therapy not become part of the problem, and take a rather cynical view of therapy's place in society generally.[4]

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[4] Item 46 ("Therapy is a growing social problem...") received the highest overall rank from the extended sample (N = 13).

Only one statement about the family/contextual basis of problem maintenance appears in the top 10 — and may not belong: Item 45, while ranked high enough to qualify as a consensus item, was also a difference item as shown below. In general, the consensus items have more to do with intervention than with family dynamics or sytems thinking.

AIFT approach favors breadth on both immediate and historical dimensions; in MRI's brief therapy, where the focus is limited to the presenting problem and how people attempt to deal with it, the relevant context is consistently narrow and immediate. The Haley and Minuchin representatives favor immediate but not historical breadth, aligning with AIFT/Milan on the first contextual dimension and MRI on the second.

Similar differences are seen on concepts requiring abstraction and inference. In their commitment to conceptual parsimony, the MRI respondents stand apart in giving lower ranks to items about homeostasis (item 40), hierarchy (item 7), and the idea that symptoms serve a function for the family or its members (item 37). Responses to item 19 suggest that the Palo Alto therapists reject these concepts because they resemble psychodynamic formulations of underlying cause (1). Haley (7) has also made the point that "homeostasis" is an idea that can handicap therapists, and (accordingly) the FTIW scores for the homeostasis item, like MRI's, are lower than those from PCGC and AIFT. MRI is alone, however, in opposing the seemingly related idea that the symptom has a function.

In the area of technique, PCGC's raters place greater emphasis than the others on grappling actively with the system as a member (item 35), and challenging transactions directly in the therapy room (item 9). The structural representatives also attach least importance to paradox (item 56), suggesting again that their approach is the most direct of the four. In other areas, AIFT respondents endorse the Milan concept of neutrality (item 53) more than colleagues at PCGC and FTIW; the Haley representatives are least enthusiastic about consultation teams and one-way mirrors (item 42);[6] and MRI's brief therapists, not surprisingly, are most concerned that therapy be brief (item 23)![7]

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[6] From the FTIW perspective, teams and mirrors, while helpful in training, may invite organizational confusion among helpers and make it difficult for therapists to learn to work on their own (R. Belson, personal communication).

[7] Other analyses identified items differentiating each model from the combined mean of the other three (15). By this criterion, with $p<.05$, MRI was above the mean on items 19, 27, 23, 39, 10, 42, below on 45, 7, 37, 40, 47, 35; PCGC above on 45, 35, 40, 9, 54, 52, below on 56, 31; FTIW above on 7, 56, 36, 33, 14, below on 2, 42, 52, 11; AIFT above on 2, 20, 53, 26, below on 54, 38.

Correlations Among Models

Of 28 correlations among eight Q-sorts (Table 4), 26 are positive and half statistically significant. This means that, in general, the eight sorts of the 60 statements are more similar than different. A principle components factor analysis[8] yielded three factors accounting for over 70% of the common variance. After rotation, the PCGC and FTIW raters loaded together on the first factor, with MRI and AIFT respondents on the second and third factors, respectively.[9] While not shown, the patterns of factor scores for factors 2 and 3 correspond closely to the average item ranks for MRI and AIFT in Table 1. Items 3 and 18, about taking charge of therapy, had the highest factor scores on the FTIW-PCGC factor. Other items with high scores on this factor (#s 35, 21, 47) further highlight the active, engaging role of the therapist in these two approaches.

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[8] In this and subsequent analyses, factors were extracted using SPSS algorithm PA1 (15) with unities in the diagonal of the correlation matrix (16). Factors with eigenvalues greater than 1.0 were rotated to a varimax solution.

[9] Repeating this analysis with the extended sample (i.e., with 13 Q-sorts rather than 8) yielded four factors rather than three: Each pair of model representatives appears on a <u>different</u> factor, joined by at least one of the other five experts. Factor 1 includes Coyne, Segal and Goolishian; factor 2, Mazza, Belson and Todd; factor three, Hoffman, McGoldrick, Walker and Penn; and factor 4, Fishman, Colapinto and Stanton. Stanton's Q-sort also loaded significantly on factor 2.

Table 4 near here

The overall relationships among the four models are summarized in Table 5, which shows correlations among four averaged Q-sorts based on combined data for each pair of raters. Not surprisingly, the strongest relationship (r = .42) is between Minuchin's and Haley's approaches. However, PCGC also correlates significantly with AIFT (r = .25), as does FTIW with MRI (r = .29). The six correlations reduce to two factors: PCGC, AIFT and FTIW load on the first, with MRI joined on the second factor by FTIW, which loads equally and significantly on both.

Table 5 near here

A final set of analyses (Table 6) test[5] the hypothesis that the models are more divergent in theory than tec nique. As already mentioned, most of the 60 items could be roughly classified as pertaining either to (a) conceptions of problem maintenance, or (b) principles of intervention. Correlating models over the 18 problem-maintenance items reveals only two significant relationships: a positive correlation between PCGC and FTIW, and a negative one for AIFT and MRI. Consistent with the item differences described above, factor analysis finds PCGC and FTIW loading together on one theory factor with MRI and AIFT at opposite poles of a (bi-polar) second. A quite different pattern emerges when the models are correlated over the 39 intervention items: Here, all correlations are positive, with only one (MRI - PCGC) not significant. Factor analysis reveals a single (general) factor accounting for over half of the total variance. Thus, in the realm of technique at least, there is statistical evidence that the four models are variations of a common theme, or paradigm.

Table 6 near here

Discussion

Despite common roots in cybernetics and systems theory, the four strategic systems therapies may share less in concept than technique. The results suggest

that the models share a practical, strategic orientation to change, but differ in their conceptions of how problems are maintained systemically.

Rankings of individual Q-sort items highlight several interrelated dimensions which divide the models conceptually. One dimension is history: AIFT's systemic therapists, like Bowen, attach importance to broad multi-generational patterns, but the other approaches do not. Another is breadth of present context: MRI's brief therapists focus narrowly on the presenting problem and the (mostly) dyadic solution cycles immediately surrounding it; the other models emphasize broader organizational characteristics and include at least three people in the conceptual problem unit. The Palo Alto group also prefers to minimize clinical inference and abstraction, acknowledging neither family "structure" or the functionality of symptoms. This contrasts sharply with the Ackerman/Milan approach where hypothesizing and inference are central. Differences in technique, while less dramatic, most often involved the PCGC structural approach, which is more direct and challenging than the other three.

Factor analyses of "model" Q-sorts suggest that, in practice, the four approaches are closely related — enough so to be considered variations of a common clinical (if not theoretical) paradigm. Actually the correlations between models are conservative, since they are based on an instrument designed to accentuate differences. Had a broader range of items been included — covering, say, the entire domain of family therapy — the statistical relationships among these particular models would have been much stronger. This does not mean, of course, that the strategic systems therapies are distinct from or unrelated to other approaches not included in the study. There are clear similarities, for example, between Bowen's work and the AIFT/Milan approach(es), and between behavioral and strategic orientations generally.

One of the limitations of quantitative results such as these is that their meaningfulness depends on the content validity of the item sample. We cannot be

assured, for example, that the a priori scheme used in constructing the Q-sort (18) is a reasonable one, or that the models and their potential similarities and differences are evenly represented. Nor is there assurance that the respondents were equally committed to the task, or even to the models they were asked to represent. (As mentioned earlier, the Milan approach is probably not represented as purely as the other three. However, there are now several Milan approaches (21), and unambiguous data might have been difficult to obtain anyway.) Another limitation is that the distinction between problem maintenance (theory) and problem resolution (intervention) items used in several analyses is only approximate. The author and a colleague were able to agree, after the fact, on the classifications shown in Appendix 1, but other judges may have grouped the items differently. It would have been better to establish clear content categories in advance (9).

Nevertheless, a similar pattern of theoretical divergence and technical convergence has been reported by Green and Kolevzon (4), who compared "communications" (Satir), "systems" (Bowen), and "structural/strategic" (Minuchin/Haley) orientations in a survey of 1000 AAMFT and AFTA members. Despite major differences in methodology and focus, the parallel results of these two studies add generality to the finding that divisions in the family therapy movement are more theoretical than practical.

The strategic systems therapies appear to agree more about being "strategic" than about being "systemic". Given the current interest in epistemology, it seems ironic that a technical consensus may be closer at hand than one based on an ecosystemic view of clinical problems. Whether or not integration is possible (or even advisable), there is reason to consider how it may occur. One view, expressed by Cloe Madanes at a recent symposium on "Integrating Ideas in Family Therapy" (11), is that

> ....a shared way of understanding a problem in therapy develops before shared techniques for solving the problem are achieved (p. 1) ....

> ..Just as a common set of ideas is now being arrived at, perhaps in the future the different schools of family therapy will also develop a shared therapeutic approach (p. 5).

The other possibility is that integration will proceed (if it does at all) from method to theory. Indeed, the systems therapies are growing rapidly, with developments in technique seeming to outstrip those in theory and research. If a new paradigm is really emerging, its articulation may depend on a closer examination of relationships among the many family therapy fiefdoms than has been possible to date.

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Table 1

High and Low-Ranked Q-Sort Items *

	MRI	PCGC	FTIW	AIFT	Institutes combined
Highest-ranked item	27	35	3	20	41
	23	45	7	41	55
	6	5	14	46	6
	19	32	36	51	32
	55	41	44	2	44
	1	9	1	45	46
	17	40	6	.	15
	39	47	18	.	1
	44	52	41	.	3
	.	.	56	.	45
	.	.	.	.	.
	.	.	.	.	.
	.	.	.	.	.
	.	.	.	.	19
	.	59	.	.	54
	24	17	59	.	53
	9	2	42	.	20
	40	53	8	.	8
	37	31	53	12	31
	20	19	19	10	2
	2	12	20	21	59
	28	48	12	48	48
Lowest-ranked item	12	20	2	54	12

* Table entried are item numbers (Appendix 1); brackets indicate ties.

Table 2

Consensus Items *

41.	Reframing (redefining the meaning of events and behavior) is an essential ingredient of therapeutic intervention. (7.75)
55.	Suggestions and directives are most effective when they are compatible with the client's (or family's) own idiosyncratic "language." (7.25)
6.	The clearer the problem definition and goal(s) of therapy, the better the outcome. (6.88)
32.	The "reality" of meaning and value is relative: Life is what you say it is. (6.63)
44.	It is not necessary (or even helpful) for the therapist to share his strategy openly with the clients. (6.63)
46.	"Therapy" is a growing social problem: As a habit, it can be enormously expensive and time consuming; as a solution, it may only perpetuate the problem. (6.63)
15.	If a problem can be solved without the family knowing how or why, that is satisfactory. (6.50)
1.	Resolving the presenting problem is a sufficient index of positive therapeutic change. (6.38)
3.	It is important for the therapist to be in charge of a case, including decisions to medicate, hospitalize, or discharge. (6.38)
45.	It is useful to think of the problem unit as including at least three people. (6.25)

* Mean Q-sort category scores shown in parentheses.

Table 3

Difference Items
(with item means and ANOVA results)

		(1) MRI	(2) PCGC	(3) FTIW	(4) AIFT	ANOVA SIGNIF. LEVEL	LSD TEST *
2.	Understanding pathological family interaction usually requires historical (cross-generational) information.	2.0	2.5	1.0	7.5	.002	3 1 2 4
45.	It is useful to think of the problem unit as including at least three people.	3.0	8.5	6.0	7.5	.003	1 3 4 2
7.	Symptomatic behavior reflects a confused or incongruous organizational hierarchy.	3.0	4.5	8.5	6.0	.003	1 2 4 3
20.	Genograms and family event charts are useful assessment tools.	2.0	1.5	1.5	9.0	.004	2 3 1 4
19.	Viewing problems as manifestations of underlying organizational dynamics is reminiscent of psychodynamic "iceberg" formulations which systems approaches should move beyond.	8.0	2.0	2.0	3.0	.012	2 3 4 1
27.	Problems are maintained by well-intentioned but self-defeating attempts to solve them.	9.0	4.0	4.5	5.5	.017	2 3 4 1
40.	Symptoms usually reflect the homeostatic imperatives of a family system in danger of change.	2.0	7.5	3.0	6.0	.021	1 3 4 2
37.	It is important to ascertain what function, use or benefit a problem presents for the family and its members.	2.0	5.5	6.5	6.0	.023	1 2 3 4

DIFFERENCE ITEMS (cont.)	(1) MRI	(2) PCGC	(3) FTIW	(4) AIFT	(P)	LSD TEST
35. The therapist should grapple actively with the system as a member, entering and (un) balancing coalitions to provoke change.	3.5	9.0	5.0	4.5	.030	1 4 3 2
52. Therapeutic change is accompanied by stress, and the therapist must be capable of dealing with it.	4.5	7.5	3.5	7.0	.035	3 1 4 2
54. Ours is a family therapy.	3.5	6.0	4.0	1.0	.042	4 1 3 2
23. Therapy should be brief.	8.5	5.0	5.5	4.5	.044	4 2 3 1
56. Often it is useful to intervene indirectly, or paradoxically, with change following from rebellion or defiance.	6.0	3.5	7.5	6.0	.044	2 1 4 3
53. The therapist should remain neutral during the interview, aligning with everyone, but no one. If asked about the therapist's true opinions and judgements of them, family members should be puzzled and uncertain.	4.5	2.0	2.0	6.0	.048	2 3 1 4
9. The therapist should challenge dysfunctional transaction patterns directly, as they occur in the therapy room.	2.5	7.5	3.5	4.5	.057	1 3 4 2
42. Whenever possible, therapy should be done with a consultation team and a one-way mirror.	6.0	5.0	2.5	4.5	.063	3 4 2 1

* Least Significant Difference test (15). Model means not sharing a common underline are different at $p < .05$.

Table 4

Relationships Among Q-Sorts

a. Correlation matrix

	Coyne	Segal	Fishman	Colapinto	Mazza	Belson	Walker	Penn
Coyne (MRI)	1.00							
Segal (MRI)	.66*	1.00						
Fishman (PCGC)	-.07	-.06	1.00					
Colapinto (PCGC)	.13	-.01	.55*	1.00				
Mazza (FTIW)	.32*	.14	.34*	.37*	1.00			
Belson (FTIW)	.29*	.23*	.30*	.39*	.74*	1.00		
Walker (AIFT)	.15	.00	.08	.22*	.07	.13	1.00	
Penn (AIFT)	.09	.03	.22*	.22*	.12	.13	.42*	1.00

* r significant at $p < .05$ (one-tailed test)

b. Matrix of factor loadings

	Factor 1	Factor 2	Factor 3	h^2
Coyne (MRI)	.13	(.88)	.12	.81
Segal (MRI)	-.00	(.87)	-.00	.75
Fishman (PCGC)	(.72)	-.27	.18	.61
Colapinto (PCGC)	(.72)	-.08	.29	.62
Mazza (FTIW)	(.80)	.30	-.07	.74
Belson (FTIW)	(.77)	.35	-.01	.72
Walker (AIFT)	.05	.08	(.83)	.67
Penn (AIFT)	.14	.02	(.80)	.70
% variance	33.4	20.8	15.9	

Table 5

Relationships Among Models

a. Correlation matrix

	MRI	PCGC	FTIW	AIFT
MRI	1.00			
PCGC	-.00	1.00		
FTIW	.29*	.42**	1.00	
AIFT	.09	.25*	.15	1.00

* r significant at $p < .05$ (one-tailed test)
** r significant at $p < .01$ (one-tailed test)

b. Matrix of factor loadings

	Factor 1	Factor 2	h^2
MRI	-.08	(.93)	.87
PCGC	(.85)	.03	.73
FTIW	(.58)	(.58)	.67
AIFT	(.63)	-.00	.40
% variance	37.6	33.4	

Table 6

Relationships among Models in Theory and Practice

a. Correlations over 18 Problem-Maintenance Items

	MRI	PCGC	FTIW	AIFT
MRI	1.00			
PCGC	-.12	1.00		
FTIW	-.05	.43**	1.00	
AIFT	-.39*	.06	-.05	1.00

* r significant at p<.10 (two-tailed test)
** " " " <.05 " " "

b. Problem maintenance factor analysis

	Factor 1	Factor 2	h^2
MRI	-.11	(-.82)	.69
PCGC	(.84)	.12	.71
FTIW	(.85)	-.06	.73
AIFT	-.06	(.84)	.71
% variance	37.6	33.4	

c, Correlations over 39 Problem-Resoultion Items

	MRI	PCGC	FTIW	AIFT
MRI	1.00			
PCGC	.10	1.00		
FTIW	.47*	.44*	1.00	
AIFT	.43*	.40*	.30*	1.00

* r significant at p < .05 (Two-tailed test)

d. Problem resolution factor analysis

	Factor 1
MRI	(.49)
PCGC	(.43)
FTIW	(.61)
AIFT	(.54)
% variance	53.7

Appendix 1

Q-Sort/Questionnaire Items

1. Resolving the presenting problem is a sufficient index of positive therapeutic change. (PR)

2. Understanding pathological family interaction usually requires historical (cross-generational) information. (PM)

3. It is important for the therapist to be in charge of a case, including decisions to medicate, hospitalize, or discharge. (PR)

4. The therapist should be available to clients between sessions. (PR)

5. Symptoms occur in family relationships where people are either too involved with each other or not involved enough. (PM)

6. The clearer the problem definition and goal(s) of therapy, the better the outcome. (PR)

7. Symptomatic behavior reflects a confused or incongruous organizational hierarchy. (PM)

8. As a rule, it is helpful for the therapist to take a one-down position with clients to minimize resistance. (PR)

9. The therapist should challenge dysfunctional transaction patterns directly, as they occur in the therapy room. (PR)

10. Knowing what to do in therapy is less important than knowing what not to do: Any of many interventions may work as long as they avoid more of the same. (PR)

11. Most clinical problems are associated with family-life transitions where the task is for one generation to disengage from another. (PM)

12. Co-therapy, with two therapists participating in the interview, is a useful way to work with families. (PR)

13. "Internal processes" (clients' thoughts, feelings, etc.) are not as relevant to therapy as concrete, observable behavior.

14. Symptomatic behavior may be a metaphor for other problems or issues in the family. (PM)

15. If a problem can be solved without the family knowing how or why, that is satisfactory. (PR)

16. Change in families occurs in discontinuous leaps or "transformations" and, for the most part, is unpredictable. (PR)

17. Goals should be set explicitly with clients at the outset of therapy. (PR)

18. The therapist should take active charge of the therapy, assuming an expert position. (PR

19. Viewing problems as manifestations of underlying organizational dynamics is reminiscent of psychodynamic "iceberg" formulations which systems approaches should move beyond. (PM)

20. Genograms and family event charts are useful assessment tools. (PM)

21. Family members should be induced to enact their habitual patterns of relating during the therapy session. (PR)

22. Systems outside the nuclear family should be included in therapy. (PR)

23. Therapy should be brief. (PR)

24. Focusing narrowly on the presenting problem is too simplistic if family dynamics are disregarded. (PM)

25. Problems are usually maintained in simple positive feedback loops (the more X, the more Y). (PM)

26. As a rule, the therapist (or team) should meet with the entire family and include everyone in tasks and prescriptions. (PR)

27. Problems are maintained by well-intentioned but self-defeating attempts to solve them. (PM)

28. The aesthetic dimension of therapy (its beauty, or elegance) is too often underemphasized.

29. The therapist's influence should be invisible: When change occurs, he must avoid taking even the slightest credit for it. (PR)

30. Whenever possible, interventions should be direct and straightforward, with change following from compliance with the therapist's suggestions and directives. (PR)

31. It is often helpful to intensify or block expressions of affect during therapy. (PR)

32. The "reality" of meaning and value is relative: Life is what you say it is. (PM)

33. Problems are maintained by paradoxical communications which conflict at different logical levels. (PM)

34. Effective interventions force a broad reorganization of the entire family system. (PR)

35. The therapist should grapple actively with the system as a member, entering and (un)balancing coalitions to provoke change. (PR)

36. In troubled families, when the parents are unified, put in charge, when the children are put lower in the hierarchy, the problems usually disappear. (PR)

37. It is important to ascertain what function, use or benefit a problem presents for the family and its members. (PM)

38. Therapy should proceed in stages. (PR)

39. The specific interaction sequences surrounding a problem are more relevant to therapy than the organizational structures which those sequences define. (PM)

40. Symptoms usually reflect the homeostatic imperatives of a family system in danger of change. (PM)

41. Reframing (redefining the meaning of events and behavior) is an essential ingredient of therapeutic intervention. (PR)

42. Whenever possible, therapy should be done with a consultation team and a one-way mirror. (PR)

43. Positively connoting rigidly dysfunctional interaction patterns is a powerful way to change them. (PR)

44. It is not necessary (or even helpful) for the therapist to share his strategy openly with the clients. (PR)

45. It is useful to think of the problem unit as including at least three people. (PM)

46. "Therapy" is a growing social problem: As a habit, it can be enormously expensive and time consuming; as a solution, it may only perpetuate the problem. (PM)

47. The therapist must join the family system before attempting to change it. (PR)

48. Systemic interventions are most impactful when presented in writing (e.g., in a letter to the family from the therapists). (PR)

49. Pointing out to clients what they are doing usually provoked defensiveness and stiffens resistance to change. (PR)

50. It is often useful to see one or several family members separately. (PR)

51. Therapy is a process of sequential hypothesis testing through which hypotheses about the family system are progressively confirmed, revised or discarded. (PR)

52. Therapeutic change is accompanied by stress, and the therapist must be capable of dealing with it. (PR)

53. The therapists should remain <u>neutral</u> during the interview, aligning with everyone, but no one. If asked about the therapist's true opinions and judgements of them, family members should be puzzled and uncertain. (PR)

54. Ours is a <u>family</u> therapy.

55. Suggestions and directives are most effective when they are compatible with the client's (or family's) own idiosyncratic "language." (PR)

56. Often it is useful to intervene indirectly, or paradoxically, with change following from rebellion or defiance. (PR)

57. Error-activated (negative) feedback processes account for the persistence and stability of clinical problems. (PM)

58. Effective interventions target a small, even trivial change in a problem pattern and allow it to amplify. (PR)

59. It is best to have a long interval between sessions (e.g., a month). (PR)

60. Pessimism about change is often more therapeutic than optimism. (PR)

PM = Problem Maintenance
PR = Problem Resolution